Registered nurses in ambulatory care setting

The primary purpose of this paper is to provide an overview of the role of Registered Nurses in ambulatory care and to describe newly implemented roles. In particular, discussion will focus on implementation of Lewin's theory of transitional change for role change from coordinating role to clinical role.

INTRODUCTION:

Waves of change continue to occur in health care services and nursing is not an exclusion from this. Schifalacqua and Costello (2009) said, " Change is constant in healthcare; on a daily basis; healthcare managers and providers are dealing with new staff, new technology, new payment systems and new evidence based practices." (p 26). As nursing professionals are considered to be a backbone for any healthcare institution; hence, they are at forefront of facing any transformation in the system. Null and Bonser (1997) stated, " nursing professionals are in the middle of the storm attempting to preserve quality patient care as well as their own careers." (p 321).

While embarking on any change project several factors need to be considered. Kotter (2007) states:

" There are specific steps in transforming an organization and that the leader needs to establish a sense of urgency for the change and form a guiding coalition of supporters to create, communicate, and act on the vision. Another step is to plan for short term wins, consolidate improvements, and have the new approaches become the norm." (p. 98).

The transition of changing from one practice to another is never easy. It has its own share of rough and trough. Ulrich, et al (2002) said that " two thirds

of quality projects fail because of the prevailing culture and the resistance of the people to change". (p. 211). Therefore, any successful change project requires honest commitment from leadership which leads the team with courage and motivation. Schifalacqua and Costello (2009) said:

" It is important that management practices are aligned to support and reinforce the change, such as clinical systems, staffing, and rewards. The changing of systems and structures are vital to lasting change. The principles of change theory to all changes from a small-level change on a nursing unit to a large-scale change throughout a healthcare system." (p. 27).

Today's healthcare is very much different from past. It has now become an industry which needs to follow the culture of corporate industry while maintaining its own uniqueness. Ferrara-Love (1997) endorsed:

" The health care organization of the future will not be hospital-based; it will be patient-focused. The patients will be found in a variety of locales, such as out-patient clinics, patient homes, and long-term care facilities, not merely in hospitals." (p. 12).

With constantly changing health care needs and demands nurses are constantly being reminded of their expanded role in practice which requires competency in performing the assigned expanded role. Dimond (1995) suggested " nurses can develop safely across the traditional boundaries of medicine and nursing practice if the practitioner follows key principles." (p. 65).

Any change process requires utilization of resources in terms of human, finance, and material; hence the change process needs frequent monitoring and evaluation for its applicability and effectiveness. The successful change implementation depends upon the communication and shared values between the team members responsible for the change. Armenakis and Harris (2011) recommends that " readiness for change is distinguished from resistance to change and readiness is described in terms of the organizational members' beliefs, attitude and intentions."

Smith-Bla and Bradle (1999) said:

" Although health care organizational change is a constant phenomenon, little is understood as to how staff experiences this change. Unsuccessful change efforts have suggested the possible important relationship between understanding staff's experience and improved results". (p. 340)

Registered nurses working in hospitals desire control over nursing care and the health care environment in which care is provided (Hoffart, Schultz, & Ingersoll, 1995). A differentiated practice model is one way to achieve professional aims (Milton, Verran, Murdaugh, & Gerber, 1992).

BACKGROUND:

The subject of change is not new. However, opportunities for professional development come from changes in the delivery of healthcare. The ambulatory clinics are an integral part of any hospital; clinics are the bridge between the hospital and the community, and are utilized as a pre-hospitalization center. At one instance it serves as the area in which hospital patients are discharged but who still may require medical care. Similarly it

also plays recipient role to receive patients into the hospital thus exhibits the first impression of the institution to its customers. Null and Bonser (1997) stressed:

“ The outpatient /ambulatory services can be a vital stage in many patient journeys. It may be a patient’s only place in the hospital setting where they visit on continuous basis. So far this has been a department staffed by nurses who have no proficiency in any clinical specialty. Hence, they gain experience in several and expertise in none.” (p. 325).

Therefore, it becomes extremely important for the health care workers, working at clinics to present themselves in a manner that reflects values, mission and culture of the institution. Role of Registered Nurses (RNs) at ambulatory clinics has been a real discussion at my organization. It was especially in relation with the posting of RNs in clinic setting. The reason behind this discussion was a general perception that there is no active clinical role of registered nurses in clinics thus they are underutilized. In addition due to cost containment projects, highly paid employees efficiency was also closely monitored therefore registered nurses being highly paid among other staff categories were objected for being underutilized at outpatient clinics. Null & Bonser (1997) said “ Nonetheless, ambulatory care nurses are presented with the challenge of providing safe, quality, cost effective care for a new population of patients.” (324)

The ambulatory care setting of our hospital has specialty based clinics comprised of 127 subspecialties, at 16 different locations. Excluding clinics, outpatient/ambulatory care services also comprise urgent care settings,

community health centre, home health care services; home based palliative programs, student/employee health programs and field/workplace nursing programs.

At our institution we have skills mix staff in nursing units which consists of following categories: RNs, Registered Midwives, Lady Health Visitors, Nursing Technicians, Nursing Assistants and Clinic Receptionists. Out of 215 staff in ambulatory care setting, 75 (34. 8%) are RNs who cover all the specialties. As per staffing model of all units of ambulatory care services, nurse patient ratio should be 1: 20. On the contrary, with increasing volume each year, numbers of RNs remained consistent in the model which makes the ratio1: 33. This makes it difficult for the nurses to deal with huge volume, providing direct care and education to 100% of the patients (which is an organizational expectation), registered as an outpatient.

Moreover, these registered nurses have gone through general nursing training in their graduating school of nursing. They develop clinic based competencies during their competency based orientation conducted in the unit within first three months of their job. This on-job training is supervised by Clinical Nurse Instructor (CNI) and Clinical Nurse Specialist (CNS) of ambulatory care services.

Haas (1998) said:

“ Ambulatory care nursing is a unique realm of nursing practice. It is characterized by rapid, focused assessments of patients, long-term nurse/patient/family relationships, and teaching and translating prescriptions for care into doable activities for patients and their caregivers. Ambulatory

care nursing is a specialty practice area that is characterized by nurses responding rapidly to high volumes of patients in a short span of time while dealing with issues that are not always predictable.” (p. 16).

While reflecting the factual nursing roles and practices at ambulatory care services of our setting in the light of definition by AAACN/ANA, a big room for improvement and innovation is seen to re-conceptualize RNs roles and practices. The existing roles and responsibilities carried out by clinic RNs are much more general than the efficient clinical roles which they should be playing. As increasingly complex health care services are being provided in ambulatory settings nurses need to be clinically competent and should be utilized effectively for better clinical outcomes, to cope with advanced technology and to fulfill customer’s expectations for low cost ambulatory care settings than the expense of hospitalization. As supported by Schroeder et al (2000): “ clinical role of ambulatory care nurses can impact on costs, quality and provider and on patient satisfaction.” (p. 73).

It was now the responsibility of nursing management of ambulatory care services to relook at the roles and re-assign tasks so that the true need of registered nurses and their proper utilization is justified so, their role is sustained in clinics and perceptions of higher management regarding nurses being underutilized can be changed.

Literature search on RNs’ roles in outpatient clinics revealed that internationally there are RN-managed clinics, telephone medicated care by RNs, specialty based nurse educators, practitioner, consultants, and clinical nurse experts such as pre-operative nurse, oncology nurse, wound specialist

nurse etc (Hamner, 2005). Jackson et al (1997) describes the various roles of both traditional nurses in hospital-based clinics and clinical nurse specialists in specialist clinics. In hospital-based outpatient clinics nurses traditionally provide direct nursing care (25%) and non nursing duties (75%), whereas the CNS in a specialist clinic provides direct patient care (69%) and ‘ non nursing duties’ (31%). This may have a potential impact on costs, as ‘ non nursing duties’ can be undertaken by less skilled staff, thus there are implications for the department in terms of role definition, staffing costs and productivity levels.

At our institution, clinic nurses have done general nursing with no specialized training in assigned field/clinic. They are involved in more of coordinating activities than clinical based tasks which can have positive impact on patient care outcomes. Furthermore, ambulatory nurses rarely had exposure of dealing with acute in-patients care needs. American Academy of Ambulatory Care Nursing (AAACN, 1995) categorized roles of ambulatory care nurses as clinical, management, educational, and researcher roles. Nurse’s role emphasis should be on patient and family education, supporting patients in management of chronic disease to affect more positive health states throughout the lifespan up to and including a peaceful death in palliative patients. Jackson et al (1997) describes the various roles of both traditional nurses in hospital-based clinics and clinical nurse specialists in specialist clinics.

DISCUSSION:

The goal of the management plan was to address the issue of strengthening the role of registered nurses at ambulatory care services, to enhance

perception and justify their need in outpatient services; Lewin's three stage model was chosen to introduce the change in RN's role. The reason behind choosing Lewin's change theory was its easy and simple implementation and efficacy in bringing modification in existing practices by analyzing driving forces, restraining forces, and by targeting new innovations and implementation. The system perspective of the Kurt Lewin's theory suggests that the process of change occurs in three stages: unfreezing, moving and refreezing. For change to occur, a motivational factor should arise in order to break the ice. Green (1983) stated " within every change situation forces exist either to push the system toward changing (pro-change forces), or push it away from changing (anti-change forces)."(p. 1623). Pro-change forces act to alter the status quo and are considered important aspects of change motivation; often expressed as feelings of discomfort, inefficient functioning or inability to meet the desired goals. Anti-change forces, on the other hand, work toward maintaining equilibrium and are usually manifested as habits, rituals or policies. Unfreezing occurs when the driving forces (pro-change) become stronger than the restraining forces (anti-change). When the system is unfrozen, the moving stage starts and change occurs leading to another ' refreeze' of the system into the changed version. Subsequent changes are usually repetitions of this process (Handley and Cooney, 1992).

Stage 1: The unfreezing phase-becoming motivated to change:

The key to this phase was to answer following questions:

What is the problem which needs to be addresses by the change management project?

Who needs to be involved in the change process?

What will be the post change benefits to the organization?

What would be the likely cost of the change?

Discussion with the in charge nurse and staff nurses of ambulatory care services was held in which desired change and issue of objection of underutilization of RNs and need of role modification was highlighted and shared with the RNs group and unit management. Majority was in consensus of the need of this change as they were also dissatisfied due to people's perception of their role and lack of clinical utilization of them in their workplace. It was also discussed that changes needed should not have cost implications. It was also shared that changing the nurses' role would be potentially stressful for those taking the new role as well as for those with whom they work. The existing situation was diagnosed in terms of ' the way things are done around here', the assumptions, ground rules and norms. There was a conventional mode of physician led clinics with the nursing role being of the handmaiden. Hence, nurse's views and opinions were obtained regarding their job responsibilities at their workplace. From a broader perspective there was an impulsion for developing RNs to meet the need of multispecialty tasks at outpatient setting, with a need to demonstrate the effectiveness of any new roles created. This is supported by Lunn (1994) who notes that " apart from ethical considerations, nurses have a legal obligation to adapt to new methods and techniques during their employment, thus employers hold responsibility for the boundaries of practice for nurses." (p. 771).

Baseline knowledge and practice assessment was done for 40 RNs to assess their insight related to clinical, professional and system roles in ambulatory work setting. A questionnaire was also administered to identify RNs' satisfaction from their existing roles and responsibilities and need for the change. The gathered data revealed that 78% nurses wanted to see changes in their traditional coordinating roles, other 22% nurses were those who were already working in specialized ambulatory care clinics and settings and have had specialty specific clinical roles i. e. ophthalmology nurses, diabetes nurse educator, oncology nurse, urgent care nurses etc. On the other hand, audit results showed only 41% involvement of nurses in clinical related knowledge and patient care tasks.

Stage 2: The moving phase-change- what needs to be changed?

Once sufficient dissatisfaction with the current roles and mutual agreement for a desire for role modification was obtained, ambulatory care nursing conceptual framework from American Academy of Ambulatory Care Nursing by Haas, S. A. (2006) was searched from literature. (Please refer appendix A). The framework was liked by higher authorities and approved to be incorporated and introduced in the ambulatory care nursing model. All nurses of the outpatient services were given orientation to the conceptual framework. The literature suggests that patients value continuity of care and do not like seeing different healthcare professionals each time they access a particular service on different instances. Laine, et al (1996) found that " both patients and physicians agreed that the most crucial element of outpatient

care is clinical skill, but patients ranked provision of information higher than physicians did.” (p. 641).

Consequently, open discussions were held through meetings with nursing management, ambulatory care nurses and medical colleagues (doctors) to introduce the suggested roles from the Ambulatory care nursing conceptual framework. Rigorous training sessions were arranged for nurses for clinical concepts such as triage, health assessments, specialty based diseases and case presentations, specialty based skills assistance, patient and family education and counseling techniques etc.

Similarly cross training of nurses at acute care settings such as emergency/ urgent care units and in-patient wards was planned and initiated to give hands-on practice and exposure to ambulatory care nurses.

Applicability of RN roles taken from the framework:

Using a nominal group approach, the major areas of practice, knowledge, and skills required for ambulatory care nursing were incorporated in the framework. As identified by Haas & Nowick (2006) three broad roles were identified and implemented in ambulatory setting of our institution as “ Clinical Nursing,” “ Organizational/Systems,” and “ Professional.” Each role became the vertical axis of the conceptual framework. Ambulatory patient population was categorized as “ Healthy,” “ Acutely Ill,” “ Chronically Ill,” and “ Terminally Ill.” listed on the horizontal axis of the framework.

Clinical nursing role

Within pre-admission assessment, the aim was to develop the RN role so that he/she could get the patient’s medical history, eliminating dependence on

medical residents who were frequently busy in in-patient care when patients came to the ambulatory care setting. Nurse-led pre-admission assessment has shown to be effective and safe (Whiteley et al. 1997). Nevertheless, there was some reluctance on the part of the consultants to agree to nurse-led assessment because of fear that residents would lose the opportunity to perform the skill of history taking and physical examination. The RNs also felt that there would be inadequate time to take on this supplementary role. The recognition of suitable training for developing advanced assessment skills was also an issue that was resolved through special courses by clinical nurse specialist. However, this role may more productively be developed through a closer assessment of the educational role, as the literature suggests that pre-operative education is more complex than might be believed, with self efficacy beliefs and patient/caregivers' needs requiring more in-depth exploration (Showalter et al. 2000, Moon and Backer 2000, Montin et al. 2002). There is evidence to suggest that developing the role of the nurse specialist or practitioner can increase the continuity of care whilst still maintaining clinical standards; examples include nurse-led rheumatology follow-up (Hill 1997) and breast care follow-up (Earnshaw 1997). Such a development not only enhanced stability but also free up consultant's time within their clinic to see patients with more complex needs and to potentially increase the number of new patients that could be seen.

Cross training of RNs in the in-patient ward setting was a crucial step to expose them to actual clinical nursing; it helped them in terms of learning all the above mentioned aspects of the clinical roles.

Organization/system role:

A group of seven senior RNs was formed from different sections of ambulatory care, to be included in a review of ambulatory care related policies, protocols and work instructions.

This group was also trained for supervisory skills to cater evening shifts and weekends in absence of head nurses of respective units. Their responsibilities as supervisors were to make shift reports of sick patients, make unit rounds to observe clinical practices of staff, on the spot intervention to resolve complaints, incidences and report to head nurse. This role proved to be productive and satisfactory for nurses as well.

Stage3: The refreezing phase-making the change permanent:

The introduction of role changes were well appreciated by the consultants, management and RNs. Enhanced patient safety, patients and nurses satisfaction and most of all effective time utilization was evident. To fix these changes, slight modification in RNs job descriptions (JDs) was done to introduce these role aspects in their JDs. Furthermore, their schedules and assignments were fixed for three months period and then rotations were pre-planned.

In this instance, Lewin’s (1951) force-field analysis also served as an assessment of the driving and restraining forces that impacted on the implementation of this change process. Driving forces facilitate change because they push employees in the desired direction (Kritsonis, 2004).

These were RNs motivation and enthusiasm, pressure from higher management and doctor’s acceptance, patient’s safety and satisfaction.

There was little resistance to change in first three months of the project. Those closely working with RNs in out-patient setting were supportive of the project and worked with the team for achievement of goals. In fact, the slower than anticipated development meant that key stakeholders such as consultants did not feel threatened by the pace of the change. Also the project was limited to out-patient setting only and therefore, had null effect in in-patient units.

Evaluation:

The outcome of the strategies through implementation of conceptual framework as a change agent was assessed through measurement audits. An audit tool was developed with 19 criteria, 80% nurses were evaluated on conceptual framework through this audit tool, 74. 2% compliance was observed with knowledge and new role implementation.

50% of ambulatory nurses were trained for health assessment, performing health assessment of patients with clinical emergencies as a daily clinical task.

100% patients with clinical emergencies were identified by RNs of assigned clinics and received timely interventions and transfer to appropriate care facilities. 80% patients received education on disease, treatment plan and lifestyle modification from nurse educators in specialty based clinics.

Other gains were safe and complex patient care delivery, evident by no clinical errors and incidences in that period. Increased patient satisfaction indicated by no clinical complaints reported by patients related to poor care, delay in procedure, incomplete guidance or negligence. Consequently nurses' satisfaction was largely enhanced, assessed by subjective verbalization of nurses in open forums and meetings. Formal surveys for nurses and patient satisfaction need to be conducted to evaluate objectivity of these outcomes.

CONCLUSION:

Stephenson (1987) said, " Change would appear to be an irrevocable fact of life within western society and is ever more prominent within the health service." (p. 150). The change process is greatly enhanced by the application of a logical process through the identification of a problem, development of an implementation plan and clear monitoring and evaluation at all stages. Furthermore, the selection of an appropriate change model aided this process, something clearly demonstrated in this project with use of Lewin's (1951) theory of transitional change.

It also discovered some very hopeful aspects with regard to professional development and team working. However, it was also experienced that change is not easy, sometimes filled with unwary troubles and sometimes intimidating. Null and Bonser (1997) said:

" Opportunities for professional growth are all around. As professionals, nurses need to be willing to go outside of the box to find them. Working collaboratively across departmental lines to solve complex problems is one

way to tap into opportunities. Nurses also need to look inside themselves to find hidden potentials and learn how to educate themselves to achieve new growth. Using one another as resources can help create an environment that provides support and promotes professional growth and development.” (p. 328).

Collective strengths allowed the nursing team at ambulatory care setting to reach well beyond the confines of out-patient services to determine opportunity for professional growth and maintain quality care for the varied population of patients they serve.